

HOUSE SUBSTITUTE
FOR
HOUSE COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 1566

AN ACT

2 To repeal sections 208.010, 208.145, 208.146,
3 208.151, 208.152, 208.215, 208.631, 208.636,
4 and 208.640, RSMo, and to enact in lieu
5 thereof eleven new sections relating to
6 medical assistance cost containment within
7 the Medicaid program, with an emergency
8 clause.

9 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF MISSOURI,
10 AS FOLLOWS:

11 Section A. Sections 208.010, 208.145, 208.146, 208.151,
12 208.152, 208.215, 208.631, 208.636, and 208.640, RSMo, are
13 repealed and eleven new sections enacted in lieu thereof, to be
14 known as sections 208.010, 208.145, 208.146, 208.147. 208.151,
15 208.152, 208.212, 208.215, 208.631, 208.636, and 208.640, to read
16 as follows:

17 208.010. 1. In determining the eligibility of a claimant
18 for public assistance pursuant to this law, it shall be the duty
19 of the division of family services to consider and take into
20 account all facts and circumstances surrounding the claimant,
21 including his or her living conditions, earning capacity, income
22 and resources, from whatever source received, and if from all the

1 facts and circumstances the claimant is not found to be in need,
2 assistance shall be denied. In determining the need of a
3 claimant, the costs of providing medical treatment which may be
4 furnished pursuant to sections 208.151 to 208.158 and 208.162
5 shall be disregarded. The amount of benefits, when added to all
6 other income, resources, support, and maintenance shall provide
7 such persons with reasonable subsistence compatible with decency
8 and health in accordance with the standards developed by the
9 division of family services; provided, when a husband and wife
10 are living together, the combined income and resources of both
11 shall be considered in determining the eligibility of either or
12 both. "Living together" for the purpose of this chapter is
13 defined as including a husband and wife separated for the purpose
14 of obtaining medical care or nursing home care, except that the
15 income of a husband or wife separated for such purpose shall be
16 considered in determining the eligibility of his or her spouse,
17 only to the extent that such income exceeds the amount necessary
18 to meet the needs (as defined by rule or regulation of the
19 division) of such husband or wife living separately. In
20 determining the need of a claimant in federally aided programs
21 there shall be disregarded such amounts per month of earned
22 income in making such determination as shall be required for
23 federal participation by the provisions of the federal Social
24 Security Act (42 U.S.C.A. 301 et seq.), or any amendments
25 thereto. When federal law or regulations require the exemption

1 of other income or resources, the division of family services may
2 provide by rule or regulation the amount of income or resources
3 to be disregarded.

4 2. Benefits shall not be payable to any claimant who:

5 (1) Has or whose spouse with whom he or she is living has,
6 prior to July 1, 1989, given away or sold a resource within the
7 time and in the manner specified in this subdivision. In
8 determining the resources of an individual, unless prohibited by
9 federal statutes or regulations, there shall be included (but
10 subject to the exclusions pursuant to subdivisions (4) and (5) of
11 this subsection, and subsection 5 of this section) any resource
12 or interest therein owned by such individual or spouse within the
13 twenty-four months preceding the initial investigation, or at any
14 time during which benefits are being drawn, if such individual or
15 spouse gave away or sold such resource or interest within such
16 period of time at less than fair market value of such resource or
17 interest for the purpose of establishing eligibility for
18 benefits, including but not limited to benefits based on
19 December, 1973, eligibility requirements, as follows:

20 (a) Any transaction described in this subdivision shall be
21 presumed to have been for the purpose of establishing eligibility
22 for benefits or assistance pursuant to this chapter unless such
23 individual furnishes convincing evidence to establish that the
24 transaction was exclusively for some other purpose;

25 (b) The resource shall be considered in determining

1 eligibility from the date of the transfer for the number of
2 months the uncompensated value of the disposed of resource is
3 divisible by the average monthly grant paid or average Medicaid
4 payment in the state at the time of the investigation to an
5 individual or on his or her behalf under the program for which
6 benefits are claimed, provided that:

7 a. When the uncompensated value is twelve thousand dollars
8 or less, the resource shall not be used in determining
9 eligibility for more than twenty-four months; or

10 b. When the uncompensated value exceeds twelve thousand
11 dollars, the resource shall not be used in determining
12 eligibility for more than sixty months;

13 (2) The provisions of subdivision (1) of subsection 2 of
14 this section shall not apply to a transfer, other than a transfer
15 to claimant's spouse, made prior to March 26, 1981, when the
16 claimant furnishes convincing evidence that the uncompensated
17 value of the disposed of resource or any part thereof is no
18 longer possessed or owned by the person to whom the resource was
19 transferred;

20 (3) Has received, or whose spouse with whom he or she is
21 living has received, benefits to which he or she was not entitled
22 through misrepresentation or nondisclosure of material facts or
23 failure to report any change in status or correct information
24 with respect to property or income as required by section
25 208.210. A claimant ineligible pursuant to this subsection shall

1 be ineligible for such period of time from the date of discovery
2 as the division of family services may deem proper; or in the
3 case of overpayment of benefits, future benefits may be
4 decreased, suspended or entirely withdrawn for such period of
5 time as the division may deem proper;

6 (4) Owns or possesses resources in the sum of one thousand
7 dollars or more; provided, however, that if such person is
8 married and living with spouse, he or she, or they, individually
9 or jointly, may own resources not to exceed two thousand dollars;
10 and provided further, that in the case of a temporary assistance
11 for needy families claimant, the provision of this subsection
12 shall not apply;

13 (5) Prior to October 1, 1989, owns or possesses property of
14 any kind or character, excluding amounts placed in an irrevocable
15 prearranged funeral or burial contract pursuant to subsection 2
16 of section 436.035, RSMo, and subdivision (5) of subsection 1 of
17 section 436.053, RSMo, or has an interest in property, of which
18 he or she is the record or beneficial owner, the value of such
19 property, as determined by the division of family services, less
20 encumbrances of record, exceeds twenty-nine thousand dollars, or
21 if married and actually living together with husband or wife, if
22 the value of his or her property, or the value of his or her
23 interest in property, together with that of such husband and
24 wife, exceeds such amount;

25 (6) In the case of temporary assistance for needy families,

1 if the parent, stepparent, and child or children in the home owns
2 or possesses property of any kind or character, or has an
3 interest in property for which he or she is a record or
4 beneficial owner, the value of such property, as determined by
5 the division of family services and as allowed by federal law or
6 regulation, less encumbrances of record, exceeds one thousand
7 dollars, excluding the home occupied by the claimant, amounts
8 placed in an irrevocable prearranged funeral or burial contract
9 pursuant to subsection 2 of section 436.035, RSMo, and
10 subdivision (5) of subsection 1 of section 436.053, RSMo, one
11 automobile which shall not exceed a value set forth by federal
12 law or regulation and for a period not to exceed six months, such
13 other real property which the family is making a good-faith
14 effort to sell, if the family agrees in writing with the division
15 of family services to sell such property and from the net
16 proceeds of the sale repay the amount of assistance received
17 during such period. If the property has not been sold within six
18 months, or if eligibility terminates for any other reason, the
19 entire amount of assistance paid during such period shall be a
20 debt due the state;

21 (7) Is an inmate of a public institution, except as a
22 patient in a public medical institution.

23 3. In determining eligibility and the amount of benefits to
24 be granted pursuant to federally aided programs, the income and
25 resources of a relative or other person living in the home shall

1 be taken into account to the extent the income, resources,
2 support and maintenance are allowed by federal law or regulation
3 to be considered.

4 4. In determining eligibility and the amount of benefits to
5 be granted pursuant to federally aided programs, the value of
6 burial lots or any amounts placed in an irrevocable prearranged
7 funeral or burial contract pursuant to subsection 2 of section
8 436.035, RSMo, and subdivision (5) of subsection 1 of section
9 436.053, RSMo, shall not be taken into account or considered an
10 asset of the burial lot owner or the beneficiary of an
11 irrevocable prearranged funeral or funeral contract. For
12 purposes of this section, "burial lots" means any burial space as
13 defined in section 214.270, RSMo, and any memorial, monument,
14 marker, tombstone or letter marking a burial space. If the
15 beneficiary, as defined in chapter 436, RSMo, of an irrevocable
16 prearranged funeral or burial contract receives any public
17 assistance benefits pursuant to this chapter and if the purchaser
18 of such contract or his or her successors in interest cancel or
19 amend the contract so that any person will be entitled to a
20 refund, such refund shall be paid to the state of Missouri up to
21 the amount of public assistance benefits provided pursuant to
22 this chapter with any remainder to be paid to those persons
23 designated in chapter 436, RSMo.

24 5. In determining the total property owned pursuant to
25 subdivision (5) of subsection 2 of this section, or resources, of

1 any person claiming or for whom public assistance is claimed,
2 there shall be disregarded any life insurance policy, or
3 prearranged funeral or burial contract, or any two or more
4 policies or contracts, or any combination of policies and
5 contracts, which provides for the payment of one thousand five
6 hundred dollars or less upon the death of any of the following:

7 (1) A claimant or person for whom benefits are claimed; or

8 (2) The spouse of a claimant or person for whom benefits
9 are claimed with whom he or she is living.

10 If the value of such policies exceeds one thousand five hundred
11 dollars, then the total value of such policies may be considered
12 in determining resources; except that, in the case of temporary
13 assistance for needy families, there shall be disregarded any
14 prearranged funeral or burial contract, or any two or more
15 contracts, which provides for the payment of one thousand five
16 hundred dollars or less per family member.

17 6. Beginning September 30, 1989, when determining the
18 eligibility of institutionalized spouses, as defined in 42 U.S.C.
19 Section 1396r-5, for medical assistance benefits as provided for
20 in section 208.151 and 42 U.S.C. Sections 1396a et seq., the
21 division of family services shall comply with the provisions of
22 the federal statutes and regulations. As necessary, the division
23 shall by rule or regulation implement the federal law and
24 regulations which shall include but not be limited to the

1 establishment of income and resource standards and limitations.

2 The division shall require:

3 (1) That at the beginning of a period of continuous
4 institutionalization that is expected to last for thirty days or
5 more, the institutionalized spouse, or the community spouse, may
6 request an assessment by the division of family services of total
7 countable resources owned by either or both spouses;

8 (2) That the assessed resources of the institutionalized
9 spouse and the community spouse may be allocated so that each
10 receives an equal share;

11 (3) That upon an initial eligibility determination, if the
12 community spouse's share does not equal at least twelve thousand
13 dollars, the institutionalized spouse may transfer to the
14 community spouse a resource allowance to increase the community
15 spouse's share to twelve thousand dollars;

16 (4) That in the determination of initial eligibility of the
17 institutionalized spouse, no resources attributed to the
18 community spouse shall be used in determining the eligibility of
19 the institutionalized spouse, except to the extent that the
20 resources attributed to the community spouse do exceed the
21 community spouse's resource allowance as defined in 42 U.S.C.
22 Section 1396r-5;

23 (5) That beginning in January, 1990, the amount specified
24 in subdivision (3) of this subsection shall be increased by the
25 percentage increase in the consumer price index for all urban

1 consumers between September, 1988, and the September before the
2 calendar year involved; and

3 (6) That beginning the month after initial eligibility for
4 the institutionalized spouse is determined, the resources of the
5 community spouse shall not be considered available to the
6 institutionalized spouse during that continuous period of
7 institutionalization.

8 7. Beginning July 1, 1989, institutionalized individuals
9 shall be ineligible for the periods required and for the reasons
10 specified in 42 U.S.C. Section 1396p.

11 8. The hearings required by 42 U.S.C. Section 1396r-5 shall
12 be conducted pursuant to the provisions of section 208.080.

13 9. Beginning October 1, 1989, when determining eligibility
14 for assistance pursuant to this chapter there shall be
15 disregarded unless otherwise provided by federal or state
16 statutes, the home of the applicant or recipient when the home is
17 providing shelter to the applicant or recipient, or his or her
18 spouse or dependent child. The division of family services shall
19 establish by rule or regulation in conformance with applicable
20 federal statutes and regulations a definition of the home and
21 when the home shall be considered a resource that shall be
22 considered in determining eligibility.

23 10. Reimbursement for services provided by an enrolled
24 Medicaid provider to a recipient who is duly entitled to Title
25 XIX Medicaid and Title XVIII Medicare Part B, Supplementary

1 Medical Insurance (SMI) shall include payment in full of
2 deductible and coinsurance amounts as determined due pursuant to
3 the applicable provisions of federal regulations pertaining to
4 Title XVIII Medicare Part B, except the applicable Title XIX cost
5 sharing.

6 11. A "community spouse" is defined as being the
7 noninstitutionalized spouse.

8 12. An institutionalized spouse applying for Medicaid and
9 having a spouse living in the community shall be required, to the
10 maximum extent permitted by law, to divert income to such
11 community spouse to raise the community spouse's income to the
12 level of the minimum monthly needs allowance, as described in 42
13 U.S.C. Section 1396r-5. Such diversion of income shall occur
14 before the community spouse is allowed to retain assets in excess
15 of the community spouse protected amount described in 42 U.S.C.
16 Section 1396r-5.

17 208.145. 1. For the purposes of the application of section
18 208.151, individuals shall be deemed to be recipients of aid to
19 families with dependent children and individuals shall be deemed
20 eligible for such assistance if:

21 (1) The individual meets eligibility requirements which are
22 no more restrictive than the July 16, 1996, eligibility
23 requirements for aid to families with dependent children, as
24 established by the division of family services; or

25 (2) Each dependent child, and each relative with whom such

1 a child is living including the spouse of such relative as
2 described in 42 U.S.C. 606(b), as in effect on July 16, 1996,
3 who ceases to meet the eligibility criteria set forth in
4 subdivision (1) of this section as a result of the collection or
5 increased collection of child or spousal support under part IV-D
6 of the Social Security Act, 42 U.S.C. 651 et seq., and who has
7 received such aid in at least three of the six months immediately
8 preceding the month in which ineligibility begins, shall be
9 deemed eligible for an additional four calendar months beginning
10 with the month in which such ineligibility begins.

11 2. In addition to any other eligibility requirements, any
12 person listed in subsection 1 of this section shall not be
13 eligible for benefits if the parent and child or children in the
14 home owns or possesses resources that exceed one thousand
15 dollars; provided that, if such person is married and living with
16 a spouse, the parents and child or children may own resources not
17 to exceed two thousand dollars. The following assets shall be
18 excluded:

19 (1) The home occupied by the claimant as the claimant's
20 principal place of residence. For town or city property, lots on
21 which there is no dwelling and which adjoin the residence are
22 considered a part of the home, regardless of the number of lots
23 so long as they are in the same city block. For rural property,
24 the acreage on which the home is located plus any adjoining
25 acreage shall be considered part of the home. Property shall be

1 considered as adjoining even though a road may separate two
2 tracts;

3 (2) One automobile. Additional automobiles shall be
4 excluded if providing transportation for any of the following
5 purposes: employment, school or church attendance, or obtaining
6 medical care;

7 (3) Real or personal property that produces annual income
8 consistent with its fair market value if it is being used
9 directly by the claimant in the course of the claimant's business
10 or employment;

11 (4) Household furnishings, household goods, and personal
12 effects used by the claimant;

13 (5) Wedding and engagement rings;

14 (6) Jewelry, other than wedding and engagement rings, that
15 is of limited value;

16 (7) Amounts placed in an irrevocable prearranged funeral or
17 burial contract under subsection 2 of section 436.035, RSMo, and
18 subdivision (5) of subsection 1 of section 436.053, RSMo;

19 (8) Up to one thousand five hundred dollars cash surrender
20 value per person of any life insurance policy, or prearranged
21 funeral or burial contract, or any two or more policies or
22 contracts, or any combination of policies or contracts. The
23 value of an irrevocable prearranged funeral or burial contract
24 shall be counted toward the one thousand five hundred dollar
25 exclusion before the exclusion is applied to other life insurance

1 policies or prearranged funeral or burial contracts;

2 (9) One burial lot per person. For purposes of this
3 section, "burial lot" means any burial space as defined in
4 section 214.270, RSMo, and any memorial, monument, marker,
5 tombstone, or letter marking a burial space;

6 (10) Payments made from the Agent Orange Settlement Fund or
7 any other fund established under the settlement in the *In Re*
8 *Agent Orange* product liability litigation, M.D.L. No. 381
9 (E.D.N.Y.) shall not be considered income or resources in
10 determining eligibility for or the amount of benefits under any
11 state or state-assisted program;

12 (11) Any proceeds from involuntary conversion of real
13 property into personal property, such as forced transfer under
14 condemnation, eminent domain, and fire, flood, or other act of
15 God, received by a recipient while eligible to receive public
16 assistance benefits under existing laws shall be considered real
17 property and excluded from resources for a period of one year
18 from the time of their receipt. For purposes of this
19 subdivision, "receipt" means actual receipt of the proceeds or
20 the payment into court of the proceeds; except that in
21 condemnation cases when the initial exception to the
22 commissioner's award is filed by the condemning authority,
23 "receipt" means receipt of an award under a final judgment;

24 (12) Relocation payments received by a claimant through the
25 Uniform Relocation Assistance Act of 1970. Section 216 of Public

1 Law 91-646 states that payments to help a recipient resettle when
2 property purchased by the state transportation department or
3 property purchased under the Housing Act causes an assistance
4 recipient to relocate shall not be considered in determining
5 eligibility for public assistance;

6 (13) Settlement payments made from the Ricky Ray Hemophilia
7 Relief Fund, or paid as a result of a class action settlement in
8 the case of *Susan Walker v. Bayer Corporation*;

9 (14) Radiation Exposure Compensation Act payments
10 authorized by Public Law 101-426, enacted October 15, 1990;

11 (15) Payments received by any member of the Passamaquoddy
12 Indian Tribe, the Penobscot Nation, or the Houlton Band of
13 Malisett Indians under the Maine Indian Claims Act of 1980,
14 Public Law 96-420;

15 (16) Payments received by any member of the Aroostook Band
16 of Micmacs under the Aroostook Band of Micmacs Settlement Act,
17 Public Law 102-171;

18 (17) For a period not to exceed six months, such real
19 property that the family is making a good faith effort to sell;

20 (18) In addition to the exclusions set forth above, all
21 exclusions set forth in any federal law that is applicable to
22 Title XIX, Public Law 89-97, 1965 amendments to the federal
23 Social Security Act (42 U.S.C. section 301 et seq.) as amended
24 shall also apply.

25 208.146. 1. Pursuant to the federal Ticket to Work and

1 Work Incentives Improvement Act of 1999 (TWWIIA) (Public Law
2 106-170), the medical assistance provided for in section 208.151
3 may be paid for a person who is employed and who:

4 (1) Meets the definition of disabled under the supplemental
5 security income program or meets the definition of an employed
6 individual with a medically improved disability under TWWIIA;

7 (2) Meets the asset limits in subsection 2 of this section;
8 and

9 (3) Has a gross income of two hundred fifty percent or less
10 of the federal poverty guidelines. For purposes of this
11 subdivision, "income" does not include any income of the person's
12 spouse up to one hundred thousand dollars or children.

13 Individuals with incomes in excess of one hundred fifty percent
14 of the federal poverty level shall pay a premium for
15 participation in accordance with subsection 5 of this section.

16 2. For purposes of determining eligibility pursuant to this
17 section, a person's assets shall not include:

18 (1) Any spousal assets up to one hundred thousand dollars,
19 one-half of any marital assets and all assets excluded pursuant
20 to section 208.010;

21 (2) Retirement accounts, including individual accounts,
22 401(k) plans, 403(b) plans, Keogh plans and pension plans;

23 (3) Medical expense accounts set up through the person's
24 employer;

25 (4) Family development accounts established pursuant to

1 sections 208.750 to 208.775; or

2 (5) PASS plans.

3 3. A person who is otherwise eligible for medical
4 assistance pursuant to this section shall not lose his or her
5 eligibility if such person maintains an independent living
6 development account. For purposes of this section, an
7 "independent living development account" means an account
8 established and maintained to provide savings for transportation,
9 housing, home modification, and personal care services and
10 assistive devices associated with such person's disability.
11 Independent living development accounts and retirement accounts
12 pursuant to subdivision (2) of subsection 2 of this section shall
13 be limited to deposits of earned income and earnings on such
14 deposits made by the eligible individual while participating in
15 the program and shall not be considered an asset for purposes of
16 determining and maintaining eligibility pursuant to section
17 208.151 until such person reaches the age of sixty-five.

18 4. If an eligible individual's employer offers
19 employer-sponsored health insurance and the department of social
20 services determines that it is more cost effective, the
21 individual shall participate in the employer- sponsored
22 insurance. The department shall pay such individual's portion of
23 the premiums, co-payments and any other costs associated with
24 participation in the employer-sponsored health insurance.

25 5. Any person whose income exceeds one hundred fifty

1 percent of the federal poverty level shall pay a premium for
2 participation in the medical assistance provided in this section.
3 The premium shall be:

4 (1) For a person whose income is between one hundred
5 fifty-one and one hundred seventy-five percent of the federal
6 poverty level, four percent of income at one hundred sixty-three
7 percent of the federal poverty level;

8 (2) For a person whose income is between one hundred
9 seventy-six and two hundred percent of the federal poverty level,
10 five percent of income at one hundred eighty-eight percent of the
11 federal poverty level;

12 (3) For a person whose income is between two hundred one
13 and two hundred twenty-five percent of the federal poverty level,
14 six percent of income at two hundred thirteen percent of the
15 federal poverty level;

16 (4) For a person whose income is between two hundred
17 twenty-six and two hundred fifty percent of the federal poverty
18 level, seven percent of income at two hundred thirty-eight
19 percent of the federal poverty level.

20 6. If the department elects to pay employer-sponsored
21 insurance pursuant to subsection 4 of this section then the
22 medical assistance established by this section shall be provided
23 to an eligible person as a secondary or supplemental policy to
24 any employer-sponsored benefits which may be available to such
25 person.

1 7. The department of social services shall submit the
2 appropriate documentation to the federal government for approval
3 which allows the resources listed in subdivisions (1) to (5) of
4 subsection 2 of this section and subsection 3 of this section to
5 be exempt for purposes of determining eligibility pursuant to
6 this section.

7 8. The department of social services shall apply for any
8 and all grants which may be available to offset the costs
9 associated with the implementation of this section.

10 9. The department of social services shall not contract for
11 the collection of premiums pursuant to this chapter. To the best
12 of their ability, the department shall collect premiums through
13 the monthly electronic funds transfer or employer deduction.

14 10. Recipients of services through this chapter who pay a
15 premium shall do so by electronic funds transfer or employer
16 deduction unless good cause is shown to pay otherwise.

17 11. Notwithstanding any other provision of law to the
18 contrary, in any given fiscal year, any persons made eligible for
19 medical assistance benefits under subsections 1 to 6 of this
20 section shall only be eligible if annual appropriations are made
21 for such eligibility. This subsection shall not apply to classes
22 of individuals listed in 42 U.S.C. Section 1396a(a)(10)(A)(i).

23 208.147. 1. The department shall conduct an annual income
24 and eligibility verification review of each recipient of medical
25 assistance. Such review shall be completed not later than twelve

1 months after the recipient's last eligibility determination.

2 2. The annual eligibility review requirement may be
3 satisfied by the completion of a periodic food stamp
4 redetermination for the household, or for households not subject
5 to an asset limit, upon completion of a review of wages
6 identified in a wage match with the division of employment
7 security. The family support division may also verify
8 information through inquiry into the personal property and
9 driver's licensing systems of the department of revenue, or
10 through other data matches.

11 3. The department shall by rule establish procedures that
12 require applicants to disclose at the time of application whether
13 their employer offers employer-sponsored health insurance that
14 they are eligible to receive, whether the applicant participates
15 in the employer-sponsored health insurance program, and to
16 disclose the applicant's reason for not participating in the
17 employer-sponsored plan, if applicable.

18 4. The department shall promulgate rules that require all
19 recipients of medical assistance to participate in cost-sharing
20 activities, subject to the provisions of 42 U.S.C. Section 1396o.

21 5. For purposes of determining the copayment amount
22 described in subsection 4 of this section, the following
23 guidelines shall apply:

24 (1) For services in which the state's payment for the
25 service is ten dollars or less, the maximum copayment shall be

1 fifty cents;

2 (2) For services in which the state's payment for the
3 service is between ten dollars one cent and twenty-five dollars,
4 the maximum copayment shall be one dollar;

5 (3) For services in which the state's payment for the
6 service is between twenty-five dollars one cent and fifty
7 dollars, the maximum copayment shall be two dollars; and

8 (4) For services in which the state's payment for the
9 service is more than fifty dollars, the maximum copayment shall
10 be three dollars.

11 6. Any copayments for which participants are responsible
12 under subsection 5 of this section shall be a credit against any
13 payments owed by the state for such services; except that if such
14 copayment is not paid by the participant, the state shall pay the
15 amount of the credit to the provider if a claim is made to the
16 division of medical services as outlined in subdivision (3) of
17 subsection 7 of this section.

18 7. If a mandatory copayment is not paid, the provider may:

19 (1) Forego the copayment; or

20 (2) Make arrangements for future payments with the
21 recipient; or

22 (3) The provider shall make reasonable efforts to collect
23 copayments. After such efforts, the provider may file a claim
24 with the division of medical services certifying that the
25 copayment is uncollected and upon certification may secure

1 payment for the service from the division of medical services.

2 The division may establish by rule the certification procedure.

3 8. When the division of medical services receives a claim
4 from a provider for nonpayment of a mandatory copayment, the
5 division shall send a notice to the recipient. Such notice
6 shall:

7 (1) Request the recipient to reimburse the division of
8 medical services for the mandatory copayment made on the
9 recipient's behalf; and

10 (2) Request information from the recipient to determine
11 whether the mandatory copayment was not made because of a change
12 in the financial situation of the recipient.

13 208.151. 1. For the purpose of paying medical assistance
14 on behalf of needy persons and to comply with Title XIX, Public
15 Law 89-97, 1965 amendments to the federal Social Security Act (42
16 U.S.C. Section 301 et seq.) as amended, the following needy
17 persons shall be eligible to receive medical assistance to the
18 extent and in the manner hereinafter provided:

19 (1) All recipients of state supplemental payments for the
20 aged, blind and disabled;

21 (2) All recipients of aid to families with dependent
22 children benefits, including all persons under nineteen years of
23 age who would be classified as dependent children except for the
24 requirements of subdivision (1) of subsection 1 of section
25 208.040;

1 (3) All recipients of blind pension benefits;

2 (4) All persons who would be determined to be eligible for
3 old age assistance benefits, permanent and total disability
4 benefits, or aid to the blind benefits under the eligibility
5 standards in effect December 31, 1973, or less restrictive
6 standards as established by rule of the division of family
7 services, who are sixty-five years of age or over and are
8 patients in state institutions for mental diseases or
9 tuberculosis;

10 (5) All persons under the age of twenty-one years who would
11 be eligible for aid to families with dependent children except
12 for the requirements of subdivision (2) of subsection 1 of
13 section 208.040, and who are residing in an intermediate care
14 facility, or receiving active treatment as inpatients in
15 psychiatric facilities or programs, as defined in 42 U.S.C.
16 1396d, as amended;

17 (6) All persons under the age of twenty-one years who would
18 be eligible for aid to families with dependent children benefits
19 except for the requirement of deprivation of parental support as
20 provided for in subdivision (2) of subsection 1 of section
21 208.040;

22 (7) All persons eligible to receive nursing care benefits;

23 (8) All recipients of family foster home or nonprofit
24 private child-care institution care, subsidized adoption benefits
25 and parental school care wherein state funds are used as partial

1 or full payment for such care;

2 (9) All persons who were recipients of old age assistance
3 benefits, aid to the permanently and totally disabled, or aid to
4 the blind benefits on December 31, 1973, and who continue to meet
5 the eligibility requirements, except income, for these assistance
6 categories, but who are no longer receiving such benefits because
7 of the implementation of Title XVI of the federal Social Security
8 Act, as amended;

9 (10) Pregnant women who meet the requirements for aid to
10 families with dependent children, except for the existence of a
11 dependent child in the home;

12 (11) Pregnant women who meet the requirements for aid to
13 families with dependent children, except for the existence of a
14 dependent child who is deprived of parental support as provided
15 for in subdivision (2) of subsection 1 of section 208.040;

16 (12) Pregnant women or infants under one year of age, or
17 both, whose family income does not exceed an income eligibility
18 standard equal to one hundred eighty-five percent of the federal
19 poverty level as established and amended by the federal
20 Department of Health and Human Services, or its successor agency;

21 (13) Children who have attained one year of age but have
22 not attained six years of age who are eligible for medical
23 assistance under 6401 of P.L. 101-239 (Omnibus Budget
24 Reconciliation Act of 1989). The division of family services
25 shall use an income eligibility standard equal to one hundred

1 thirty-three percent of the federal poverty level established by
2 the Department of Health and Human Services, or its successor
3 agency;

4 (14) Children who have attained six years of age but have
5 not attained nineteen years of age. For children who have
6 attained six years of age but have not attained nineteen years of
7 age, the division of family services shall use an income
8 assessment methodology which provides for eligibility when family
9 income is equal to or less than equal to one hundred percent of
10 the federal poverty level established by the Department of Health
11 and Human Services, or its successor agency. As necessary to
12 provide Medicaid coverage under this subdivision, the department
13 of social services may revise the state Medicaid plan to extend
14 coverage under 42 U.S.C. 1396a (a)(10)(A)(i)(III) to children who
15 have attained six years of age but have not attained nineteen
16 years of age as permitted by paragraph (2) of subsection (n) of
17 42 U.S.C. 1396d using a more liberal income assessment
18 methodology as authorized by paragraph (2) of subsection (r) of
19 42 U.S.C. 1396a;

20 (15) The following children with family income which does
21 not exceed two hundred percent of the federal poverty guideline
22 for the applicable family size:

23 (a) Infants who have not attained one year of age with
24 family income greater than one hundred eighty-five percent of the
25 federal poverty guideline for the applicable family size;

1 (b) Children who have attained one year of age but have not
2 attained six years of age with family income greater than one
3 hundred thirty-three percent of the federal poverty guideline for
4 the applicable family size; and

5 (c) Children who have attained six years of age but have
6 not attained nineteen years of age with family income greater
7 than one hundred percent of the federal poverty guideline for the
8 applicable family size.

9 Coverage under this subdivision shall be subject to the receipt
10 of notification by the director of the department of social
11 services and the revisor of statutes of approval from the
12 secretary of the U.S. Department of Health and Human Services of
13 applications for waivers of federal requirements necessary to
14 promulgate regulations to implement this subdivision. The
15 director of the department of social services shall apply for
16 such waivers. The regulations may provide for a basic primary
17 and preventive health care services package, not to include all
18 medical services covered by section 208.152, and may also
19 establish co-payment, coinsurance, deductible, or premium
20 requirements for medical assistance under this subdivision.
21 Eligibility for medical assistance under this subdivision shall
22 be available only to those infants and children who do not have
23 or have not been eligible for employer-subsidized health care
24 insurance coverage for the six months prior to application for

1 medical assistance. Children are eligible for
2 employer-subsidized coverage through either parent, including the
3 noncustodial parent. The division of family services may
4 establish a resource eligibility standard in assessing
5 eligibility for persons under this subdivision. The division of
6 medical services shall define the amount and scope of benefits
7 which are available to individuals under this subdivision in
8 accordance with the requirement of federal law and regulations.
9 Coverage under this subdivision shall be subject to appropriation
10 to provide services approved under the provisions of this
11 subdivision;

12 (16) The family support division [of family services] shall
13 not establish a resource eligibility standard in assessing
14 eligibility for [persons] infants under subdivision (12) of this
15 subsection, or children under subdivision, (13) or (14) of this
16 subsection. The division of medical services shall define the
17 amount and scope of benefits which are available to individuals
18 eligible under each of the subdivisions (12), (13), and (14) of
19 this subsection, in accordance with the requirements of federal
20 law and regulations promulgated thereunder except that the scope
21 of benefits shall include case management services;

22 (17) Notwithstanding any other provisions of law to the
23 contrary, ambulatory prenatal care shall be made available to
24 pregnant women during a period of presumptive eligibility
25 pursuant to 42 U.S.C. Section 1396r-1, as amended;

1 (18) A child born to a woman eligible for and receiving
2 medical assistance under this section on the date of the child's
3 birth shall be deemed to have applied for medical assistance and
4 to have been found eligible for such assistance under such plan
5 on the date of such birth and to remain eligible for such
6 assistance for a period of time determined in accordance with
7 applicable federal and state law and regulations so long as the
8 child is a member of the woman's household and either the woman
9 remains eligible for such assistance or for children born on or
10 after January 1, 1991, the woman would remain eligible for such
11 assistance if she were still pregnant. Upon notification of such
12 child's birth, the division of family services shall assign a
13 medical assistance eligibility identification number to the child
14 so that claims may be submitted and paid under such child's
15 identification number;

16 (19) Pregnant women and children eligible for medical
17 assistance pursuant to subdivision (12), (13) or (14) of this
18 subsection shall not as a condition of eligibility for medical
19 assistance benefits be required to apply for aid to families with
20 dependent children. The division of family services shall
21 utilize an application for eligibility for such persons which
22 eliminates information requirements other than those necessary to
23 apply for medical assistance. The division shall provide such
24 application forms to applicants whose preliminary income
25 information indicates that they are ineligible for aid to

1 families with dependent children. Applicants for medical
2 assistance benefits under subdivision (12), (13) or (14) shall be
3 informed of the aid to families with dependent children program
4 and that they are entitled to apply for such benefits. Any forms
5 utilized by the division of family services for assessing
6 eligibility under this chapter shall be as simple as practicable;

7 (20) Subject to appropriations necessary to recruit and
8 train such staff, the division of family services shall provide
9 one or more full-time, permanent case workers to process
10 applications for medical assistance at the site of a health care
11 provider, if the health care provider requests the placement of
12 such case workers and reimburses the division for the expenses
13 including but not limited to salaries, benefits, travel,
14 training, telephone, supplies, and equipment, of such case
15 workers. The division may provide a health care provider with a
16 part-time or temporary case worker at the site of a health care
17 provider if the health care provider requests the placement of
18 such a case worker and reimburses the division for the expenses,
19 including but not limited to the salary, benefits, travel,
20 training, telephone, supplies, and equipment, of such a case
21 worker. The division may seek to employ such case workers who
22 are otherwise qualified for such positions and who are current or
23 former welfare recipients. The division may consider training
24 such current or former welfare recipients as case workers for
25 this program;

1 (21) Pregnant women who are eligible for, have applied for
2 and have received medical assistance under subdivision (2), (10),
3 (11) or (12) of this subsection shall continue to be considered
4 eligible for all pregnancy-related and postpartum medical
5 assistance provided under section 208.152 until the end of the
6 sixty-day period beginning on the last day of their pregnancy;

7 (22) Case management services for pregnant women and young
8 children at risk shall be a covered service. To the greatest
9 extent possible, and in compliance with federal law and
10 regulations, the department of health and senior services shall
11 provide case management services to pregnant women by contract or
12 agreement with the department of social services through local
13 health departments organized under the provisions of chapter 192,
14 RSMo, or chapter 205, RSMo, or a city health department operated
15 under a city charter or a combined city-county health department
16 or other department of health and senior services designees. To
17 the greatest extent possible the department of social services
18 and the department of health and senior services shall mutually
19 coordinate all services for pregnant women and children with the
20 crippled children's program, the prevention of mental retardation
21 program and the prenatal care program administered by the
22 department of health and senior services. The department of
23 social services shall by regulation establish the methodology for
24 reimbursement for case management services provided by the
25 department of health and senior services. For purposes of this

1 section, the term "case management" shall mean those activities
2 of local public health personnel to identify prospective
3 Medicaid-eligible high-risk mothers and enroll them in the
4 state's Medicaid program, refer them to local physicians or local
5 health departments who provide prenatal care under physician
6 protocol and who participate in the Medicaid program for prenatal
7 care and to ensure that said high-risk mothers receive support
8 from all private and public programs for which they are eligible
9 and shall not include involvement in any Medicaid prepaid,
10 case-managed programs;

11 (23) By January 1, 1988, the department of social services
12 and the department of health and senior services shall study all
13 significant aspects of presumptive eligibility for pregnant women
14 and submit a joint report on the subject, including projected
15 costs and the time needed for implementation, to the general
16 assembly. The department of social services, at the direction of
17 the general assembly, may implement presumptive eligibility by
18 regulation promulgated pursuant to chapter 207, RSMo;

19 (24) All recipients who would be eligible for aid to
20 families with dependent children benefits except for the
21 requirements of paragraph (d) of subdivision (1) of section
22 208.150;

23 (25) All persons who would be determined to be eligible for
24 old age assistance benefits, permanent and total disability
25 benefits, or aid to the blind benefits, under the eligibility

standards in effect December 31, 1973; except that, on or after July 1, 2002, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), shall be used to raise the income limit to eighty percent of the federal poverty level and, as of July 1, 2003, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), shall be used to raise the income limit to ninety percent of the federal poverty level and, as of July 1, 2004, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), shall be used to raise the income limit to one hundred percent of the federal poverty level. If federal law or regulation authorizes the division of family services to, by rule, exclude the income or resources of a parent or parents of a person under the age of eighteen and such exclusion of income or resources can be limited to such parent or parents, then notwithstanding the provisions of section 208.010:

(a) The division may by rule exclude such income or resources in determining such person's eligibility for permanent and total disability benefits; and

(b) Eligibility standards for permanent and total disability benefits shall not be limited by age;

(26) Within thirty days of the effective date of an initial appropriation authorizing medical assistance on behalf of "medically needy" individuals for whom federal reimbursement is available under 42 U.S.C. 1396a (a)(10)(C), the department of

1 social services shall submit an amendment to the Medicaid state
2 plan to provide medical assistance on behalf of, at a minimum, an
3 individual described in subclause (I) or (II) of clause 42 U.S.C.
4 1396a (a)(10)(C)(ii);

5 (27) Persons who have been diagnosed with breast or
6 cervical cancer and who are eligible for coverage pursuant to 42
7 U.S.C. 1396a (a)(10)(A)(ii)(XVIII). Such persons shall be
8 eligible during a period of presumptive eligibility in accordance
9 with 42 U.S.C. 1396r-1.

10 2. Rules and regulations to implement this section shall be
11 promulgated in accordance with section 431.064, RSMo, and chapter
12 536, RSMo. Any rule or portion of a rule, as that term is
13 defined in section 536.010, RSMo, that is created under the
14 authority delegated in this section shall become effective only
15 if it complies with and is subject to all of the provisions of
16 chapter 536, RSMo, and, if applicable, section 536.028, RSMo.
17 This section and chapter 536, RSMo, are nonseverable and if any
18 of the powers vested with the general assembly pursuant to
19 chapter 536, RSMo, to review, to delay the effective date or to
20 disapprove and annul a rule are subsequently held
21 unconstitutional, then the grant of rulemaking authority and any
22 rule proposed or adopted after August 28, 2002, shall be invalid
23 and void.

24 3. After December 31, 1973, and before April 1, 1990, any
25 family eligible for assistance pursuant to 42 U.S.C. 601 et seq.,

1 as amended, in at least three of the last six months immediately
2 preceding the month in which such family became ineligible for
3 such assistance because of increased income from employment
4 shall, while a member of such family is employed, remain eligible
5 for medical assistance for four calendar months following the
6 month in which such family would otherwise be determined to be
7 ineligible for such assistance because of income and resource
8 limitation. After April 1, 1990, any family receiving aid
9 pursuant to 42 U.S.C. 601 et seq., as amended, in at least three
10 of the six months immediately preceding the month in which such
11 family becomes ineligible for such aid, because of hours of
12 employment or income from employment of the caretaker relative,
13 shall remain eligible for medical assistance for six calendar
14 months following the month of such ineligibility as long as such
15 family includes a child as provided in 42 U.S.C. 1396r-6. Each
16 family which has received such medical assistance during the
17 entire six-month period described in this section and which meets
18 reporting requirements and income tests established by the
19 division and continues to include a child as provided in 42
20 U.S.C. 1396r-6 shall receive medical assistance without fee for
21 an additional six months. The division of medical services may
22 provide by rule the scope of medical assistance coverage to be
23 granted to such families.

24 4. For purposes of Section 1902(1), (10) of Title XIX of
25 the federal Social Security Act, as amended, any individual who,

1 for the month of August, 1972, was eligible for or was receiving
2 aid or assistance pursuant to the provisions of Titles I, X, XIV,
3 or Part A of Title IV of such act and who, for such month, was
4 entitled to monthly insurance benefits under Title II of such
5 act, shall be deemed to be eligible for such aid or assistance
6 for such month thereafter prior to October, 1974, if such
7 individual would have been eligible for such aid or assistance
8 for such month had the increase in monthly insurance benefits
9 under Title II of such act resulting from enactment of Public Law
10 92-336 amendments to the federal Social Security Act (42 U.S.C.
11 301 et seq.), as amended, not been applicable to such individual.

12 5. When any individual has been determined to be eligible
13 for medical assistance, such medical assistance will be made
14 available to him for care and services furnished in or after the
15 third month before the month in which he made application for
16 such assistance if such individual was, or upon application would
17 have been, eligible for such assistance at the time such care and
18 services were furnished; provided, further, that such medical
19 expenses remain unpaid.

20 6. The department of social services may apply to the
21 federal Department of Health and Human Services for a Medicaid
22 waiver amendment to the Section 1115 demonstration waiver or for
23 any additional Medicaid waivers necessary and desirable to
24 implement the increased income limit, as authorized in
25 subdivision (25) of subsection 1 of this section.

1 7. In addition to any other eligibility requirements, any
2 pregnant woman listed in subdivision (10), (11), or (12) of
3 subsection 1 of this section shall not be eligible for benefits
4 if the pregnant woman owns or possesses resources that exceed two
5 thousand dollars; provided that, if such woman is married and
6 living with a spouse, she or he, or they, individually or
7 jointly, may own resources not to exceed three thousand dollars.
8 The following assets shall be excluded:

9 (1) The home occupied by the claimant as the claimant's
10 principal place of residence. For town or city property, lots on
11 which there is no dwelling and which adjoin the residence are
12 considered a part of the home, regardless of the number of lots
13 so long as they are in the same city block. For rural property,
14 the acreage on which the home is located plus any adjoining
15 acreage shall be considered part of the home. Property shall be
16 considered as adjoining even though a road may separate two
17 tracts;

18 (2) One automobile. Additional automobiles shall be
19 excluded if providing transportation for any of the following
20 purposes: employment, school or church attendance, or obtaining
21 medical care;

22 (3) Real or personal property that produces annual income
23 consistent with its fair market value if it is being used
24 directly by the claimant in the course of the claimant's business
25 or employment;

1 (4) Household furnishings, household goods, and personal
2 effects used by the claimant;

3 (5) Wedding and engagement rings;

4 (6) Jewelry, other than wedding and engagement rings, that
5 is of limited value;

6 (7) Amounts placed in an irrevocable prearranged funeral or
7 burial contract under subsection 2 of section 436.035, RSMo, and
8 subdivision (5) of subsection 1 of section 436.053, RSMo;

9 (8) Up to one thousand five hundred dollars cash surrender
10 value per person of any life insurance policy, or prearranged
11 funeral or burial contract, or any two or more policies or
12 contracts, or any combination of policies or contracts. The
13 value of an irrevocable prearranged funeral or burial contract
14 shall be counted toward the one thousand five hundred dollar
15 exclusion before the exclusion is applied to other life insurance
16 policies or prearranged funeral or burial contracts;

17 (9) One burial lot per person. For purposes of this
18 section, "burial lot" means any burial space as defined in
19 section 214.270, RSMo, and any memorial, monument, marker,
20 tombstone, or letter marking a burial space;

21 (10) Payments made from the Agent Orange Settlement Fund or
22 any other fund established under the settlement in the *In Re*
23 *Agent Orange* product liability litigation, M.D.L. No. 381
24 (E.D.N.Y.) shall not be considered income or resources in
25 determining eligibility for or the amount of benefits under any

1 state or state-assisted program;

2 (11) Any proceeds from involuntary conversion of real
3 property into personal property, such as forced transfer under
4 condemnation, eminent domain, and fire, flood, or other act of
5 God, received by a recipient while eligible to receive public
6 assistance benefits under existing laws shall be considered real
7 property and excluded from resources for a period of one year
8 from the time of their receipt. For purposes of this
9 subdivision, "receipt" means actual receipt of the proceeds or
10 the payment into court of the proceeds; except that in
11 condemnation cases when the initial exception to the
12 commissioner's award is filed by the condemning authority,
13 "receipt" means receipt of an award under a final judgment;

14 (12) Relocation payments received by a claimant through the
15 Uniform Relocation Assistance Act of 1970. Section 216 of Public
16 Law 91-646 states that payments to help a recipient resettle when
17 property purchased by the state transportation department or
18 property purchased under the Housing Act causes an assistance
19 recipient to relocate shall not be considered in determining
20 eligibility for public assistance;

21 (13) Settlement payments made from the Ricky Ray Hemophilia
22 Relief Fund, or paid as a result of a class action settlement in
23 the case of *Susan Walker v. Bayer Corporation*;

24 (14) Radiation Exposure Compensation Act payments
25 authorized by Public Law 101-426, enacted October 15, 1990;

1 (15) Payments received by any member of the Passamaquoddy
2 Indian Tribe, the Penobscot Nation, or the Houlton Band of
3 Malisett Indians under the Maine Indian Claims Act of 1980,
4 Public Law 96-420;

5 (16) Payments received by any member of the Aroostook Band
6 of Micmacs under the Aroostook Band of Micmacs Settlement Act,
7 Public Law 102-171;

8 (17) For a period not to exceed six months, such real
9 property that the family is making a good faith effort to sell;

10 (18) In addition to the exclusions set forth above, all
11 exclusions set forth in any federal law that is applicable to
12 Title XIX, Public Law 89-97, 1965 amendments to the federal
13 Social Security Act (42 U.S.C. section 301 et seq.) as amended
14 shall also apply.

15 8. Notwithstanding any other provision of law to the
16 contrary, in any given fiscal year, any persons made eligible for
17 medical assistance benefits under subdivisions (1) to (27) of
18 subsection 1 of this section shall only be eligible if annual
19 appropriations are made for such eligibility. This subsection
20 shall not apply to classes of individuals listed in 42 U.S.C.
21 Section 1396a(a)(10)(A)(i).

22 208.152. 1. Benefit payments for medical assistance shall
23 be made on behalf of those eligible needy persons who are unable
24 to provide for it in whole or in part, with any payments to be
25 made on the basis of the reasonable cost of the care or

1 reasonable charge for the services as defined and determined by
2 the division of medical services, unless otherwise hereinafter
3 provided, for the following:

4 (1) Inpatient hospital services, except to persons in an
5 institution for mental diseases who are under the age of
6 sixty-five years and over the age of twenty-one years; provided
7 that the division of medical services shall provide through rule
8 and regulation an exception process for coverage of inpatient
9 costs in those cases requiring treatment beyond the seventy-fifth
10 percentile professional activities study (PAS) or the Medicaid
11 children's diagnosis length-of-stay schedule; and provided
12 further that the division of medical services shall take into
13 account through its payment system for hospital services the
14 situation of hospitals which serve a disproportionate number of
15 low-income patients;

16 (2) All outpatient hospital services, payments therefor to
17 be in amounts which represent no more than eighty percent of the
18 lesser of reasonable costs or customary charges for such
19 services, determined in accordance with the principles set forth
20 in Title XVIII A and B, Public Law 89-97, 1965 amendments to the
21 federal Social Security Act (42 U.S.C. 301, et seq.), but the
22 division of medical services may evaluate outpatient hospital
23 services rendered under this section and deny payment for
24 services which are determined by the division of medical services
25 not to be medically necessary, in accordance with federal law and

1 regulations;

2 (3) Laboratory and X-ray services;

3 (4) Nursing home services for recipients, except to persons
4 in an institution for mental diseases who are under the age of
5 sixty-five years, when residing in a hospital licensed by the
6 department of health and senior services or a nursing home
7 licensed by the division of aging or appropriate licensing
8 authority of other states or government-owned and -operated
9 institutions which are determined to conform to standards
10 equivalent to licensing requirements in Title XIX, of the federal
11 Social Security Act (42 U.S.C. 301, et seq.), as amended, for
12 nursing facilities. The division of medical services may
13 recognize through its payment methodology for nursing facilities
14 those nursing facilities which serve a high volume of Medicaid
15 patients. The division of medical services when determining the
16 amount of the benefit payments to be made on behalf of persons
17 under the age of twenty-one in a nursing facility may consider
18 nursing facilities furnishing care to persons under the age of
19 twenty-one as a classification separate from other nursing
20 facilities;

21 (5) Nursing home costs for recipients of benefit payments
22 under subdivision (4) of this section for those days, which shall
23 not exceed twelve per any period of six consecutive months,
24 during which the recipient is on a temporary leave of absence
25 from the hospital or nursing home, provided that no such

1 recipient shall be allowed a temporary leave of absence unless it
2 is specifically provided for in his plan of care. As used in
3 this subdivision, the term "temporary leave of absence" shall
4 include all periods of time during which a recipient is away from
5 the hospital or nursing home overnight because he is visiting a
6 friend or relative;

7 (6) Physicians' services, whether furnished in the office,
8 home, hospital, nursing home, or elsewhere;

9 (7) Dental services;

10 (8) Services of podiatrists as defined in section 330.010,
11 RSMo;

12 (9) Drugs and medicines when prescribed by a licensed
13 physician, dentist, or podiatrist;

14 (10) Emergency ambulance services and, effective January 1,
15 1990, medically necessary transportation to scheduled,
16 physician-prescribed nonelective treatments. The department of
17 social services may conduct demonstration projects related to the
18 provision of medically necessary transportation to recipients of
19 medical assistance under this chapter. Such demonstration
20 projects shall be funded only by appropriations made for the
21 purpose of such demonstration projects. If funds are
22 appropriated for such demonstration projects, the department
23 shall submit to the general assembly a report on the significant
24 aspects and results of such demonstration projects;

25 (11) Early and periodic screening and diagnosis of

1 individuals who are under the age of twenty-one to ascertain
2 their physical or mental defects, and health care, treatment, and
3 other measures to correct or ameliorate defects and chronic
4 conditions discovered thereby. Such services shall be provided
5 in accordance with the provisions of section 6403 of P.L.[53]
6 101-239 and federal regulations promulgated thereunder;

7 (12) Home health care services;

8 (13) Optometric services as defined in section 336.010,
9 RSMo;

10 (14) Family planning as defined by federal rules and
11 regulations; provided, however, that such family planning
12 services shall not include abortions unless such abortions are
13 certified in writing by a physician to the Medicaid agency that,
14 in his professional judgment, the life of the mother would be
15 endangered if the fetus were carried to term;

16 (15) Orthopedic devices or other prosthetics, including eye
17 glasses, dentures, hearing aids, and wheelchairs;

18 (16) Inpatient psychiatric hospital services for
19 individuals under age twenty-one as defined in Title XIX of the
20 federal Social Security Act (42 U.S.C. 1396d, et seq.);

21 (17) Outpatient surgical procedures, including presurgical
22 diagnostic services performed in ambulatory surgical facilities
23 which are licensed by the department of health and senior
24 services of the state of Missouri; except, that such outpatient
25 surgical services shall not include persons who are eligible for

1 coverage under Part B of Title XVIII, Public Law 89-97, 1965
2 amendments to the federal Social Security Act, as amended, if
3 exclusion of such persons is permitted under Title XIX, Public
4 Law 89-97, 1965 amendments to the federal Social Security Act, as
5 amended;

6 (18) Personal care services which are medically oriented
7 tasks having to do with a person's physical requirements, as
8 opposed to housekeeping requirements, which enable a person to be
9 treated by his physician on an outpatient, rather than on an
10 inpatient or residential basis in a hospital, intermediate care
11 facility, or skilled nursing facility. Personal care services
12 shall be rendered by an individual not a member of the
13 recipient's family who is qualified to provide such services
14 where the services are prescribed by a physician in accordance
15 with a plan of treatment and are supervised by a licensed nurse.
16 Persons eligible to receive personal care services shall be those
17 persons who would otherwise require placement in a hospital,
18 intermediate care facility, or skilled nursing facility.
19 Benefits payable for personal care services shall not exceed for
20 any one recipient one hundred percent of the average statewide
21 charge for care and treatment in an intermediate care facility
22 for a comparable period of time;

23 (19) Mental health services. The state plan for providing
24 medical assistance under Title XIX of the Social Security Act, 42
25 U.S.C. 301, as amended, shall include the following mental health

1 services when such services are provided by community mental
2 health facilities operated by the department of mental health or
3 designated by the department of mental health as a community
4 mental health facility or as an alcohol and drug abuse facility.
5 The department of mental health shall establish by administrative
6 rule the definition and criteria for designation as a community
7 mental health facility and for designation as an alcohol and drug
8 abuse facility. Such mental health services shall include:

9 (a) Outpatient mental health services including preventive,
10 diagnostic, therapeutic, rehabilitative, and palliative
11 interventions rendered to individuals in an individual or group
12 setting by a mental health professional in accordance with a plan
13 of treatment appropriately established, implemented, monitored,
14 and revised under the auspices of a therapeutic team as a part of
15 client services management;

16 (b) Clinic mental health services including preventive,
17 diagnostic, therapeutic, rehabilitative, and palliative
18 interventions rendered to individuals in an individual or group
19 setting by a mental health professional in accordance with a plan
20 of treatment appropriately established, implemented, monitored,
21 and revised under the auspices of a therapeutic team as a part of
22 client services management;

23 (c) Rehabilitative mental health and alcohol and drug abuse
24 services including preventive, diagnostic, therapeutic,
25 rehabilitative, and palliative interventions rendered to

1 individuals in an individual or group setting by a mental health
2 or alcohol and drug abuse professional in accordance with a plan
3 of treatment appropriately established, implemented, monitored,
4 and revised under the auspices of a therapeutic team as a part of
5 client services management. As used in this section, "mental
6 health professional" and "alcohol and drug abuse professional"
7 shall be defined by the department of mental health pursuant to
8 duly promulgated rules. With respect to services established by
9 this subdivision, the department of social services, division of
10 medical services, shall enter into an agreement with the
11 department of mental health. Matching funds for outpatient
12 mental health services, clinic mental health services, and
13 rehabilitation services for mental health and alcohol and drug
14 abuse shall be certified by the department of mental health to
15 the division of medical services. The agreement shall establish
16 a mechanism for the joint implementation of the provisions of
17 this subdivision. In addition, the agreement shall establish a
18 mechanism by which rates for services may be jointly developed;

19 (20) Comprehensive day rehabilitation services beginning
20 early posttrauma as part of a coordinated system of care for
21 individuals with disabling impairments. Rehabilitation services
22 must be based on an individualized, goal-oriented, comprehensive
23 and coordinated treatment plan developed, implemented, and
24 monitored through an interdisciplinary assessment designed to
25 restore an individual to optimal level of physical, cognitive and

1 behavioral function. The division of medical services shall
2 establish by administrative rule the definition and criteria for
3 designation of a comprehensive day rehabilitation service
4 facility, benefit limitations and payment mechanism;

5 (21) Hospice care. As used in this subsection, the term
6 "hospice care" means a coordinated program of active professional
7 medical attention within a home, outpatient and inpatient care
8 which treats the terminally ill patient and family as a unit,
9 employing a medically directed interdisciplinary team. The
10 program provides relief of severe pain or other physical symptoms
11 and supportive care to meet the special needs arising out of
12 physical, psychological, spiritual, social and economic stresses
13 which are experienced during the final stages of illness, and
14 during dying and bereavement and meets the Medicare requirements
15 for participation as a hospice as are provided in 42 CFR Part
16 418. Beginning July 1, 1990, the rate of reimbursement paid by
17 the division of medical services to the hospice provider for room
18 and board furnished by a nursing home to an eligible hospice
19 patient shall not be less than ninety-five percent of the rate of
20 reimbursement which would have been paid for facility services in
21 that nursing home facility for that patient, in accordance with
22 subsection (c) of section 6408 of P.L. 101-239 (Omnibus Budget
23 Reconciliation Act of 1989);

24 (22) Such additional services as defined by the division of
25 medical services to be furnished under waivers of federal

1 statutory requirements as provided for and authorized by the
2 federal Social Security Act (42 U.S.C. 301, et seq.) subject to
3 appropriation by the general assembly;

4 (23) Beginning July 1, 1990, the services of a certified
5 pediatric or family nursing practitioner to the extent that such
6 services are provided in accordance with chapter 335, RSMo, and
7 regulations promulgated thereunder, regardless of whether the
8 nurse practitioner is supervised by or in association with a
9 physician or other health care provider;

10 (24) Subject to appropriations, the department of social
11 services shall conduct demonstration projects for nonemergency,
12 physician-prescribed transportation for pregnant women who are
13 recipients of medical assistance under this chapter in counties
14 selected by the director of the division of medical services.
15 The funds appropriated pursuant to this subdivision shall be used
16 for the purposes of this subdivision and for no other purpose.
17 The department shall not fund such demonstration projects with
18 revenues received for any other purpose. This subdivision shall
19 not authorize transportation of a pregnant woman in active labor.
20 The division of medical services shall notify recipients of
21 nonemergency transportation services under this subdivision of
22 such other transportation services which may be appropriate
23 during active labor or other medical emergency;

24 (25) Nursing home costs for recipients of benefit payments
25 under subdivision (4) of this subsection to reserve a bed for the

1 recipient in the nursing home during the time that the recipient
2 is absent due to admission to a hospital for services which
3 cannot be performed on an outpatient basis, subject to the
4 provisions of this subdivision:

5 (a) The provisions of this subdivision shall apply only if:

6 a. The occupancy rate of the nursing home is at or above
7 ninety-seven percent of Medicaid certified licensed beds,
8 according to the most recent quarterly census provided to the
9 division of aging which was taken prior to when the recipient is
10 admitted to the hospital; and

11 b. The patient is admitted to a hospital for a medical
12 condition with an anticipated stay of three days or less;

13 (b) The payment to be made under this subdivision shall be
14 provided for a maximum of three days per hospital stay;

15 (c) For each day that nursing home costs are paid on behalf
16 of a recipient pursuant to this subdivision during any period of
17 six consecutive months such recipient shall, during the same
18 period of six consecutive months, be ineligible for payment of
19 nursing home costs of two otherwise available temporary leave of
20 absence days provided under subdivision (5) of this subsection;
21 and

22 (d) The provisions of this subdivision shall not apply
23 unless the nursing home receives notice from the recipient or the
24 recipient's responsible party that the recipient intends to
25 return to the nursing home following the hospital stay. If the

1 nursing home receives such notification and all other provisions
2 of this subsection have been satisfied, the nursing home shall
3 provide notice to the recipient or the recipient's responsible
4 party prior to release of the reserved bed.

5 2. Benefit payments for medical assistance for surgery as
6 defined by rule duly promulgated by the division of medical
7 services, and any costs related directly thereto, shall be made
8 only when a second medical opinion by a licensed physician as to
9 the need for the surgery is obtained prior to the surgery being
10 performed.

11 3. The division of medical services may require any
12 recipient of medical assistance to pay part of the charge or
13 cost, as defined by rule duly promulgated by the division of
14 medical services, for dental services, drugs and medicines,
15 optometric services, eye glasses, dentures, hearing aids, and
16 other services, to the extent and in the manner authorized by
17 Title XIX of the federal Social Security Act (42 U.S.C. 1396, et
18 seq.) and regulations thereunder. When substitution of a generic
19 drug is permitted by the prescriber according to section 338.056,
20 RSMo, and a generic drug is substituted for a name brand drug,
21 the division of medical services may not lower or delete the
22 requirement to make a co-payment pursuant to regulations of Title
23 XIX of the federal Social Security Act. A provider of goods or
24 services described under this section must collect from all
25 recipients the partial payment that may be required by the

1 division of medical services under authority granted herein, if
2 the division exercises that authority, to remain eligible as a
3 provider. Any payments made by recipients under this section
4 shall be in addition to, and not in lieu of, any payments made by
5 the state for goods or services described herein.

6 4. The division of medical services shall have the right to
7 collect medication samples from recipients in order to maintain
8 program integrity.

9 5. Reimbursement for obstetrical and pediatric services
10 under subdivision (6) of subsection 1 of this section shall be
11 timely and sufficient to enlist enough health care providers so
12 that care and services are available under the state plan for
13 medical assistance at least to the extent that such care and
14 services are available to the general population in the
15 geographic area, as required under subparagraph (a)(30)(A) of 42
16 U.S.C. 1396a and federal regulations promulgated thereunder.

17 6. Beginning July 1, 1990, reimbursement for services
18 rendered in federally funded health centers shall be in
19 accordance with the provisions of subsection 6402(c) and section
20 6404 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989)
21 and federal regulations promulgated thereunder.

22 7. Beginning July 1, 1990, the department of social
23 services shall provide notification and referral of children
24 below age five, and pregnant, breast-feeding, or postpartum women
25 who are determined to be eligible for medical assistance under

1 section 208.151 to the special supplemental food programs for
2 women, infants and children administered by the department of
3 health and senior services. Such notification and referral shall
4 conform to the requirements of section 6406 of P.L. 101-239 and
5 regulations promulgated thereunder.

6 8. Providers of long-term care services shall be reimbursed
7 for their costs in accordance with the provisions of section 1902
8 (a)(13)(A) of the Social Security Act, 42 U.S.C. 1396a, as
9 amended, and regulations promulgated thereunder.

10 9. [Reimbursement rates to long-term care providers with
11 respect to a total change in ownership, at arm's length, for any
12 facility previously licensed and certified for participation in
13 the Medicaid program shall not increase payments in excess of the
14 increase that would result from the application of section 1902
15 (a)(13)(C) of the Social Security Act, 42 U.S.C. 1396a
16 (a)(13)(C).

17 10.] The department of social services, division of medical
18 services, may enroll qualified residential care facilities, as
19 defined in chapter 198, RSMo, as Medicaid personal care
20 providers.

21 10. Notwithstanding any other provision of law to the
22 contrary, in any given fiscal year, any optional benefit provided
23 by the department under subdivisions (1) to (25) of subsection 1
24 of section 208.152 shall only be provided if appropriations are
25 made available for such benefits. An "optional benefit" means a

1 benefit not required to be provided under 42 U.S.C. Section
2 1396a(a)(10)(A) and 42 U.S.C. Section 1396d(a)(1) to (5), (17),
3 and (21). If in any given fiscal year moneys are not
4 appropriated to fund one or more of such optional benefits, such
5 benefits shall not be provided and persons otherwise eligible for
6 such benefits shall no longer be deemed eligible.

7 208.212. 1. For purposes of Medicaid eligibility,
8 investment in annuities shall be limited to those annuities that:

9 (1) Are actuarially sound as measured against the Social
10 Security Administration Life Expectancy Tables, as amended;

11 (2) Provide equal or nearly equal payments for the duration
12 of the device and which exclude "balloon" style final payments;
13 and

14 (3) Provide the state of Missouri secondary or contingent
15 beneficiary status ensuring payment if the individual predeceases
16 the duration of the annuity, in an amount equal to the Medicaid
17 expenditure made by the state on the individual's behalf.

18 2. The department shall establish a sixty-month look-back
19 period to review any investment in an annuity by an applicant for
20 Medicaid benefits. If an investment in an annuity is determined
21 by the department to have been made in anticipation of obtaining
22 or with an intent to obtain eligibility for Medicaid benefits,
23 the department shall have available all remedies and sanctions
24 permitted under federal and state law regarding such investment.
25 The fact that an investment in an annuity which occurred prior to

1 the effective date of this section does not meet the criteria
2 established in subsection 1 of this section shall not
3 automatically result in a disallowance of such investment.

4 3. The department of social services shall promulgate rules
5 to administer the provisions of this section. Any rule or
6 portion of a rule, as that term is defined in section 536.010,
7 RSMo, that is created under the authority delegated in this
8 section shall become effective only if it complies with and is
9 subject to all of the provisions of chapter 536, RSMo, and, if
10 applicable, section 536.028, RSMo. This section and chapter 536,
11 RSMo, are nonseverable and if any of the powers vested with the
12 general assembly pursuant to chapter 536, RSMo, to review, to
13 delay the effective date, or to disapprove and annul a rule are
14 subsequently held unconstitutional, then the grant of rulemaking
15 authority and any rule proposed or adopted after August 28, 2004,
16 shall be invalid and void.

17 208.215. 1. Medicaid is payer of last resort unless
18 otherwise specified by law. When any person, corporation,
19 institution, public agency or private agency is liable, either
20 pursuant to contract or otherwise, to a recipient of public
21 assistance on account of personal injury to or disability or
22 disease or benefits arising from a health insurance plan to which
23 the recipient may be entitled, payments made by the department of
24 social services shall be a debt due the state and recoverable
25 from the liable party or recipient for all payments made in

1 behalf of the recipient and the debt due the state shall not
2 exceed the payments made from medical assistance provided under
3 sections 208.151 to 208.158 and section 208.162 and section
4 208.204 on behalf of the recipient, minor or estate for payments
5 on account of the injury, disease, or disability or benefits
6 arising from a health insurance program to which the recipient
7 may be entitled.

8 2. The department of social services may maintain an
9 appropriate action to recover funds due under this section in the
10 name of the state of Missouri against the person, corporation,
11 institution, public agency, or private agency liable to the
12 recipient, minor or estate.

13 3. Any recipient, minor, guardian, conservator, personal
14 representative, estate, including persons entitled under section
15 537.080, RSMo, to bring an action for wrongful death who pursues
16 legal rights against a person, corporation, institution, public
17 agency, or private agency liable to that recipient or minor for
18 injuries, disease or disability or benefits arising from a health
19 insurance plan to which the recipient may be entitled as outlined
20 in subsection 1 of this section shall upon actual knowledge that
21 the department of social services has paid medical assistance
22 benefits as defined by this chapter, promptly notify the
23 department as to the pursuit of such legal rights.

24 4. Every applicant or recipient by application assigns his
25 right to the department of any funds recovered or expected to be

1 recovered to the extent provided for in this section. All
2 applicants and recipients, including a person authorized by the
3 probate code, shall cooperate with the department of social
4 services in identifying and providing information to assist the
5 state in pursuing any third party who may be liable to pay for
6 care and services available under the state's plan for medical
7 assistance as provided in sections 208.151 to 208.159 and
8 sections 208.162 and 208.204. All applicants and recipients
9 shall cooperate with the agency in obtaining third-party
10 resources due to the applicant, recipient, or child for whom
11 assistance is claimed. Failure to cooperate without good cause
12 as determined by the department of social services in accordance
13 with federally prescribed standards, shall render the applicant
14 or recipient ineligible for medical assistance under sections
15 208.151 to 208.159 and sections 208.162 and 208.204.

16 5. Every person, corporation or partnership who acts for or
17 on behalf of a person who is or was eligible for medical
18 assistance under sections 208.151 to 208.159 and sections 208.162
19 and 208.204 for purposes of pursuing the applicant's or
20 recipient's claim which accrued as a result of a nonoccupational
21 or nonwork-related incident or occurrence resulting in the
22 payment of medical assistance benefits shall notify the
23 department upon agreeing to assist such person and further shall
24 notify the department of any institution of a proceeding,
25 settlement or the results of the pursuit of the claim and give

1 thirty days' notice before any judgment, award, or settlement may
2 be satisfied in any action or any claim by the applicant or
3 recipient to recover damages for such injuries, disease, or
4 disability, or benefits arising from a health insurance program
5 to which the recipient may be entitled.

6 6. Every recipient, minor, guardian, conservator, personal
7 representative, estate, including persons entitled under section
8 537.080, RSMo, to bring an action for wrongful death, or his
9 attorney or legal representative shall promptly notify the
10 department of any recovery from a third party and shall
11 immediately reimburse the department from the proceeds of any
12 settlement, judgment, or other recovery in any action or claim
13 initiated against any such third party.

14 7. The department director shall have a right to recover
15 the amount of payments made to a provider under this chapter
16 because of an injury, disease, or disability, or benefits arising
17 from a health insurance plan to which the recipient may be
18 entitled for which a third party is or may be liable in contract,
19 tort or otherwise under law or equity.

20 8. The department of social services shall have a lien upon
21 any moneys to be paid by any insurance company or similar
22 business enterprise, person, corporation, institution, public
23 agency or private agency in settlement or satisfaction of a
24 judgment on any claim for injuries or disability or disease
25 benefits arising from a health insurance program to which the

1 recipient may be entitled which resulted in medical expenses for
2 which the department made payment. This lien shall also be
3 applicable to any moneys which may come into the possession of
4 any attorney who is handling the claim for injuries, or
5 disability or disease or benefits arising from a health insurance
6 plan to which the recipient may be entitled which resulted in
7 payments made by the department. In each case, a lien notice
8 shall be served by certified mail or registered mail, upon the
9 party or parties against whom the applicant or recipient has a
10 claim, demand or cause of action. The lien shall claim the
11 charge and describe the interest the department has in the claim,
12 demand or cause of action. The lien shall attach to any verdict
13 or judgment entered and to any money or property which may be
14 recovered on account of such claim, demand, cause of action or
15 suit from and after the time of the service of the notice.

16 9. On petition filed by the department, or by the
17 recipient, or by the defendant, the court, on written notice of
18 all interested parties, may adjudicate the rights of the parties
19 and enforce the charge. The court may approve the settlement of
20 any claim, demand or cause of action either before or after a
21 verdict, and nothing in this section shall be construed as
22 requiring the actual trial or final adjudication of any claim,
23 demand or cause of action upon which the department has charge.
24 The court may determine what portion of the recovery shall be
25 paid to the department against the recovery. In making this

1 determination the court shall conduct an evidentiary hearing and
2 shall consider competent evidence pertaining to the following
3 matters:

4 (1) The amount of the charge sought to be enforced against
5 the recovery when expressed as a percentage of the gross amount
6 of the recovery; the amount of the charge sought to be enforced
7 against the recovery when expressed as a percentage of the amount
8 obtained by subtracting from the gross amount of the recovery the
9 total attorney's fees and other costs incurred by the recipient
10 incident to the recovery; and whether the department should, as a
11 matter of fairness and equity, bear its proportionate share of
12 the fees and costs incurred to generate the recovery from which
13 the charge is sought to be satisfied;

14 (2) The amount, if any, of the attorney's fees and other
15 costs incurred by the recipient incident to the recovery and paid
16 by the recipient up to the time of recovery, and the amount of
17 such fees and costs remaining unpaid at the time of recovery;

18 (3) The total hospital, doctor and other medical expenses
19 incurred for care and treatment of the injury to the date of
20 recovery therefor, the portion of such expenses theretofore paid
21 by the recipient, by insurance provided by the recipient, and by
22 the department, and the amount of such previously incurred
23 expenses which remain unpaid at the time of recovery and by whom
24 such incurred, unpaid expenses are to be paid;

25 (4) Whether the recovery represents less than substantially

1 full recompense for the injury and the hospital, doctor and other
2 medical expenses incurred to the date of recovery for the care
3 and treatment of the injury, so that reduction of the charge
4 sought to be enforced against the recovery would not likely
5 result in a double recovery or unjust enrichment to the
6 recipient;

7 (5) The age of the recipient and of persons dependent for
8 support upon the recipient, the nature and permanency of the
9 recipient's injuries as they affect not only the future
10 employability and education of the recipient but also the
11 reasonably necessary and foreseeable future material,
12 maintenance, medical rehabilitative and training needs of the
13 recipient, the cost of such reasonably necessary and foreseeable
14 future needs, and the resources available to meet such needs and
15 pay such costs;

16 (6) The realistic ability of the recipient to repay in
17 whole or in part the charge sought to be enforced against the
18 recovery when judged in light of the factors enumerated above.

19 10. The burden of producing evidence sufficient to support
20 the exercise by the court of its discretion to reduce the amount
21 of a proven charge sought to be enforced against the recovery
22 shall rest with the party seeking such reduction.

23 11. The court may reduce and apportion the department's
24 lien proportionate to the recovery of the claimant. The court
25 may consider the nature and extent of the injury, economic and

1 noneconomic loss, settlement offers, comparative negligence as it
2 applies to the case at hand, hospital costs, physician costs, and
3 all other appropriate costs. The department shall pay its pro
4 rata share of the attorney's fees based on the department's lien
5 as it compares to the total settlement agreed upon. This section
6 shall not affect the priority of an attorney's lien under section
7 484.140, RSMo. The charges of the department described in this
8 section, however, shall take priority over all other liens and
9 charges existing under the laws of the state of Missouri with the
10 exception of the attorney's lien under such statute.

11 12. Whenever the department of social services has a
12 statutory charge under this section against a recovery for
13 damages incurred by a recipient because of its advancement of any
14 assistance, such charge shall not be satisfied out of any
15 recovery until the attorney's claim for fees is satisfied,
16 irrespective of whether or not an action based on recipient's
17 claim has been filed in court. Nothing herein shall prohibit the
18 director from entering into a compromise agreement with any
19 recipient, after consideration of the factors in subsections 9 to
20 13 of this section.

21 13. This section shall be inapplicable to any claim, demand
22 or cause of action arising under the workers' compensation act,
23 chapter 287, RSMo. From funds recovered pursuant to this section
24 the federal government shall be paid a portion thereof equal to
25 the proportionate part originally provided by the federal

1 government to pay for medical assistance to the recipient or
2 minor involved. The department shall [have the right to] enforce
3 TEFRA liens, 42 U.S.C. Section 1396p, as authorized by federal
4 law and regulation on permanently institutionalized individuals.
5 The department shall have the right to enforce TEFRA liens, 42
6 U.S.C. Section 1396p, as authorized by federal law and
7 regulation. For the purposes of this subsection, "permanently
8 institutionalized individuals" means those persons who the
9 department determines cannot reasonably be expected to be
10 discharged and return home, and "property" includes the homestead
11 and all other personal and real property in which the recipient
12 has sole legal interest or a legal interest based upon
13 co-ownership of the property which is the result of a transfer of
14 property for less than the fair market value within thirty months
15 prior to the recipient's entering the nursing facility. The
16 following provisions shall apply to such liens:

17 (1) The lien shall be for the debt due the state for
18 medical assistance paid or to be paid on behalf of a recipient.
19 The amount of the lien shall be for the full amount due the state
20 at the time the lien is enforced;

21 (2) The director of the department or the director's
22 designee shall file for record, with the recorder of deeds of the
23 county in which any real property of the recipient is situated, a
24 written notice of the lien. The notice of lien shall contain the
25 name of the recipient and a description of the real estate. The

1 recorder shall note the time of receiving such notice, and shall
2 record and index the notice of lien in the same manner as deeds
3 of real estate are required to be recorded and indexed. The
4 director or the director's designee may release or discharge all
5 or part of the lien and notice of the release shall also be filed
6 with the recorder;

7 (3) No such lien may be imposed against the property of any
8 individual prior to his death on account of medical assistance
9 paid except:

10 (a) In the case of the real property of an individual:

11 a. Who is an inpatient in a nursing facility, intermediate
12 care facility for the mentally retarded, or other medical
13 institution, if such individual is required, as a condition of
14 receiving services in such institution, to spend for costs of
15 medical care all but a minimal amount of his income required for
16 personal needs; and

17 b. With respect to whom the director of the department of
18 social services or the director's designee determines, after
19 notice and opportunity for hearing, that he cannot reasonably be
20 expected to be discharged from the medical institution and to
21 return home. The hearing, if requested, shall proceed under the
22 provisions of chapter 536, RSMo, before a hearing officer
23 designated by the director of the department of social services;
24 or

25 (b) Pursuant to the judgment of a court on account of

1 benefits incorrectly paid on behalf of such individual;

2 (4) No lien may be imposed under paragraph (b) of
3 subdivision (3) of this subsection on such individual's home if
4 one or more of the following persons is lawfully residing in such
5 home:

6 (a) The spouse of such individual;

7 (b) Such individual's child who is under twenty-one years
8 of age, or is blind or permanently and totally disabled; or

9 (c) A sibling of such individual who has an equity interest
10 in such home and who was residing in such individual's home for a
11 period of at least one year immediately before the date of the
12 individual's admission to the medical institution;

13 (5) Any lien imposed with respect to an individual pursuant
14 to subparagraph b of paragraph (a) of subdivision (3) of this
15 subsection shall dissolve upon that individual's discharge from
16 the medical institution and return home.

17 14. The debt due the state provided by this section is
18 subordinate to the lien provided by section 484.130, RSMo, or
19 section 484.140, RSMo, relating to an attorney's lien and to the
20 recipient's expenses of the claim against the third party.

21 15. Application for and acceptance of medical assistance
22 under this chapter shall constitute an assignment to the
23 department of social services of any rights to support for the
24 purpose of medical care as determined by a court or
25 administrative order and of any other rights to payment for

1 medical care.

2 16. All recipients of benefits as defined in this chapter
3 shall cooperate with the state by reporting to the division of
4 family services or the division of medical services, within
5 thirty days, any occurrences where an injury to their persons or
6 to a member of a household who receives medical assistance is
7 sustained, on such form or forms as provided by the division of
8 family services or the division of medical services.

9 17. If a person fails to comply with the provision of any
10 judicial or administrative decree or temporary order requiring
11 that person to maintain medical insurance or be responsible
12 for medical expenses for a dependent child, spouse, or ex-spouse,
13 in addition to other remedies available, that person shall be
14 liable to the state for the entire cost of the medical care
15 provided pursuant to eligibility under any public assistance
16 program on behalf of that dependent child, spouse, or ex-spouse
17 during the period for which the required medical care was
18 provided. Where a duty of support exists and no judicial or
19 administrative decree or temporary order for support has been
20 entered, the person owing the duty of support shall be liable to
21 the state for the entire cost of the medical care provided on
22 behalf of the dependent child or spouse to whom the duty of
23 support is owed.

24 18. The department director or his designee may compromise,
25 settle or waive any such claim in whole or in part in the

1 interest of the medical assistance program.

2 208.631. 1. Notwithstanding any other provision of law to
3 the contrary, the department of social services shall establish a
4 program to pay for health care for uninsured children. Coverage
5 pursuant to sections 208.631 to [208.660] 208.657 is subject to
6 annual appropriation, and if funds are not appropriated for a
7 given fiscal year, individuals otherwise eligible for coverage
8 under sections 208.631 to 208.657 shall no longer be eligible.

9 The provisions of sections 208.631 to 208.657 shall be void and
10 of no effect after July 1, 2007.

11 2. For the purposes of sections 208.631 to 208.657,
12 "children" are persons up to nineteen years of age. "Uninsured
13 children" are persons up to nineteen years of age who are
14 emancipated and do not have access to affordable
15 employer-subsidized health care insurance or other health care
16 coverage or persons whose parent or guardian have not had access
17 to affordable employer-subsidized health care insurance or other
18 health care coverage for their children for six months prior to
19 application, are residents of the state of Missouri, and have
20 parents or guardians who meet the requirements in section
21 208.636. A child who is eligible for medical assistance as
22 authorized in section 208.151 is not uninsured for the purposes
23 of sections 208.631 to 208.657.

24 208.636. Parents and guardians of uninsured children
25 eligible for the program established in sections 208.631 to

1 208.657 shall:

2 (1) Furnish to the department of social services the
3 uninsured child's Social Security number or numbers, if the
4 uninsured child has more than one such number;

5 (2) Cooperate with the department of social services in
6 identifying and providing information to assist the state in
7 pursuing any third-party insurance carrier who may be liable to
8 pay for health care;

9 (3) Cooperate with the department of social services,
10 division of child support enforcement in establishing paternity
11 and in obtaining support payments, including medical support;

12 (4) Demonstrate upon request their child's participation in
13 wellness programs including immunizations and a periodic physical
14 examination. This subdivision shall not apply to any child whose
15 parent or legal guardian objects in writing to such wellness
16 programs including immunizations and an annual physical
17 examination because of religious beliefs or medical
18 contraindications; and

19 (5) Demonstrate annually that [their total net worth does
20 not exceed two hundred fifty thousand dollars in total value] the
21 parent and child or children in the home do not own or possess
22 resources which exceed one thousand dollars; provided that if
23 such person is married and living with a spouse, the parents and
24 child or children may own resources not to exceed two thousand
25 dollars. The following assets shall be excluded:

1 (1) The home occupied by the claimant as the claimant's
2 principal place of residence. For town or city property, lots on
3 which there is no dwelling and which adjoin the residence are
4 considered a part of the home, regardless of the number of lots
5 so long as they are in the same city block. For rural property,
6 the acreage on which the home is located plus any adjoining
7 acreage shall be considered part of the home. Property shall be
8 considered as adjoining even though a road may separate two
9 tracts;

10 (2) One automobile. Additional automobiles shall be
11 excluded if providing transportation for any of the following
12 purposes: employment, school or church attendance, or obtaining
13 medical care;

14 (3) Real or personal property that produces annual income
15 consistent with its fair market value if it is being used
16 directly by the claimant in the course of the claimant's business
17 or employment;

18 (4) Household furnishings, household goods, and personal
19 effects used by the claimant;

20 (5) Wedding and engagement rings;

21 (6) Jewelry, other than wedding and engagement rings, that
22 is of limited value;

23 (7) Amounts placed in an irrevocable prearranged funeral or
24 burial contract under subsection 2 of section 436.035, RSMo, and
25 subdivision (5) of subsection 1 of section 436.053, RSMo;

1 (8) Up to one thousand five hundred dollars cash surrender
2 value per person of any life insurance policy, or prearranged
3 funeral or burial contract, or any two or more policies or
4 contracts, or any combination of policies or contracts. The
5 value of an irrevocable prearranged funeral or burial contract
6 shall be counted toward the one thousand five hundred dollar
7 exclusion before the exclusion is applied to other life insurance
8 policies or prearranged funeral or burial contracts;

9 (9) One burial lot per person. For purposes of this
10 section, "burial lot" means any burial space as defined in
11 section 214.270, RSMo, and any memorial, monument, marker,
12 tombstone, or letter marking a burial space;

13 (10) Payments made from the Agent Orange Settlement Fund or
14 any other fund established under the settlement in the *In Re*
15 *Agent Orange* product liability litigation, M.D.L. No. 381
16 (E.D.N.Y.) shall not be considered income or resources in
17 determining eligibility for or the amount of benefits under any
18 state or state-assisted program;

19 (11) Any proceeds from involuntary conversion of real
20 property into personal property, such as forced transfer under
21 condemnation, eminent domain, and fire, flood, or other act of
22 God, received by a recipient while eligible to receive public
23 assistance benefits under existing laws shall be considered real
24 property and excluded from resources for a period of one year
25 from the time of their receipt. For purposes of this

1 subdivision, "receipt" means actual receipt of the proceeds or
2 the payment into court of the proceeds; except that in
3 condemnation cases when the initial exception to the
4 commissioner's award is filed by the condemning authority,
5 "receipt" means receipt of an award under a final judgment;

6 (12) Relocation payments received by a claimant through the
7 Uniform Relocation Assistance Act of 1970. Section 216 of Public
8 Law 91-646 states that payments to help a recipient resettle when
9 property purchased by the state transportation department or
10 property purchased under the Housing Act causes an assistance
11 recipient to relocate shall not be considered in determining
12 eligibility for public assistance;

13 (13) Settlement payments made from the Ricky Ray Hemophilia
14 Relief Fund, or paid as a result of a class action settlement in
15 the case of *Susan Walker v. Bayer Corporation*;

16 (14) Radiation Exposure Compensation Act payments
17 authorized by Public Law 101-426, enacted October 15, 1990;

18 (15) Payments received by any member of the Passamaquoddy
19 Indian Tribe, the Penobscot Nation, or the Houlton Band of
20 Malisett Indians under the Maine Indian Claims Act of 1980,
21 Public Law 96-420;

22 (16) Payments received by any member of the Aroostook Band
23 of Micmacs under the Aroostook Band of Micmacs Settlement Act,
24 Public Law 102-171;

25 (17) For a period not to exceed six months, such real

1 property that the family is making a good faith effort to sell;

2 (18) In addition to the exclusions set forth above, all
3 exclusions set forth in any federal law that is applicable to
4 Title XIX, Public Law 89-97, 1965 amendments to the federal
5 Social Security Act (42 U.S.C. section 301 et seq.) as amended
6 shall also apply.

7 208.640. [1. Parents and guardians of uninsured children
8 with available incomes between one hundred eighty-six and two
9 hundred twenty- five percent of the federal poverty level are
10 responsible for a five-dollar co-payment.

11 2.] Parents and guardians of uninsured children with
12 incomes between [two hundred twenty-six] one hundred fifty-one
13 and three hundred percent of the federal poverty level who do not
14 have access to affordable employer-sponsored health care
15 insurance or other affordable health care coverage may obtain
16 coverage pursuant to this subsection. For the purposes of
17 sections 208.631 to 208.657, "affordable employer-sponsored
18 health care insurance or other affordable health care coverage"
19 refers to health insurance requiring a monthly premium less than
20 or equal to one hundred thirty-three percent of the monthly
21 average premium required in the state's current Missouri
22 consolidated health care plan. The parents and guardians of
23 eligible uninsured children pursuant to this subsection are
24 responsible for co-payments equal to the average co-payments
25 required in the current Missouri consolidated health care plan

1 rounded to the nearest dollar, and a monthly premium equal to the
2 average premium required for the Missouri consolidated health
3 care plan; provided that the total aggregate cost sharing for a
4 family covered by these sections shall not exceed five percent of
5 such family's income for the years involved. No co-payments or
6 other cost sharing is permitted with respect to benefits for
7 well-baby and well-child care including age-appropriate
8 immunizations. Cost-sharing provisions pursuant to sections
9 208.631 to 208.657 shall not exceed the limits established by 42
10 U.S.C. Section 1397cc(e).

11 Section B. Because immediate action is necessary to contain
12 costs within the Medicaid program section A of this act is deemed
13 necessary for the immediate preservation of the public health,
14 welfare, peace, and safety, and is hereby declared to be an
15 emergency act within the meaning of the constitution, and section
16 A of this act shall be in full force and effect on July 1, 2004,
17 or upon its passage and approval, whichever later occurs.